

LTC Pre-Qualification Health Questionnaire

Information is used to compare rates for different insurance carriers

First, M.I., Last Name: _____

Height & Weight: _____ Date of Birth: _____

Social Security Number: _____ Marital Status: _____

Address: _____

Phone Number: _____ Best Time To Call: _____

Type of Employment: _____

Total Assets: _____ Average Annual Income: _____

Medical Information

Do you now, or have you within the past 5 years, used any tobacco products? Yes ___ No ___

List all conditions you have been treated or diagnosed with in the last 5 years (*see example below*):

Date of Diagnosis From/To	Medical Condition/Diagnosis	Name/Address/Phone# of Physician
<i>November 2000 To Present</i>	<i>High Cholesterol</i>	<i>Dr. John Smith 21 Park Avenue, New York, NY 10022 (212) 555-1234</i>

List all prescriptions you have taken within the past 12 months (*see example below*):

Medication Name & Dosage	Name of Medical Condition	Treatment Dates From/To	Name/Address/Phone# of Prescribing Physician
<i>Mevacor 20 mg, 1x day</i>	<i>High Cholesterol</i>	<i>1989 To Present</i>	<i>Dr. John Smith, 21 Park Avenue, New York, NY 10022 (212) 555-1234</i>

Note: Please attach extra sheets if needed. Return completed forms to Custom Care Solutions, LLC via fax @ 212.344.4020 or mail to 140 Broadway, 26th Floor, NY, NY, 10005, email: info@customcaresolution.com Toll Free: 800.908.2120